

Fig. 2_ Formation of the stable fibrin clot.

The concept of the Laser-Assisted New Attachment Procedure (LANAP) was born back in 1989 with Drs Robert Gregg II and Del McCarthy. As with most general dentists battling with the day-to-day realities of periodontal disease, they were looking for an answer on how to better care for their patients. The reality at the time was that periodontal disease was difficult to treat and maintain. It was primarily based on older concepts of wound debridement and amputation. Once treated, relapse was common. We know periodontal disease is a multifactorial disease process and patient behavioural routines can play a significant role. It is a wonder that the conventional treatments worked as well as they did. Even when

In concept, the LANAP protocol is rather simplistic. The ultimate goal is to set up the periodontal environment to promote self-regeneration of the lost attachment and osseous structure that result from

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Tooth Chart Symbols:
 POCKETS: (mm)
 RECESSOR: (mm)
 NO A.G. (No Attached Gingiva) = √
 MIN. A.G. (Minimum Attached Gingiva) = ✓
 MOBILITY = I (SIT) II (MOD) III (ADV)
 FURCATIONS = △ (CLJ) Δ (CLR) ▲ (CLR)

Tooth Codes:
 B = Bleeding
 S = Supuration
 N = A.N.U.G.
 D = Decay
 DR = Defective Restoration
 T = Poor Gingival Topography
 B = Distoma

Patient Information:
 DATE / PERIOD DIAGNOSIS: _____
 PERIOD TYPE: I II III IV V

Periodontal Exam Record
 ©George K. Margolis, D.D.S., 1991

DATE	EXAM TYPE	Comprehensive	Limited	Screening	Reevaluation	Post-Operative Evaluation																												
TOOTH #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32		
Pockets:	F	339	636	724	629	1016	137	633	938	636	718	506	535	649	956	746	835	535	625	525	525	525	525	525	525	525	525	525	525	525	525	525	525	
Recession:	F	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
No A.G.	F	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mn. A.G.	F	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mobility																																		
Furcations	F	D																																
(M, D)	L	X	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
Codes																																		
Other																																		

H & N Exam: • Class Malocclusion
 POS. / NEG. • Eremittus in Sliding Movements: # in C.O.: #



Fig. 5

Fig. 5 Post-op periodontal probing at 15 months.

The simplicity of the LANAP protocol can be seen in Table I.

Step A

Step B

This is the first time the laser is used. The objective of this step is to remove only diseased epithelium, to affect selectively bacteria associated with periodontal disease, to affect the calculus present, and to affect thermolabile toxins. The bacteria that are associated with periodontal diseases are pigmented and are found in the sulcus, within the root surface and within the epithelial cells. One of the reasons for the predictability of this step is in the selection of a free-running pulsed Nd:YAG laser with a wavelength of 1,064 nm and pulsed in a range of seven different microseconds. The shorter 1,064 nm wavelength was selected for its affinity for melanin or dark pigmentation, unlike the longer wavelengths that are highly absorbed in water and would have a shallow depth of



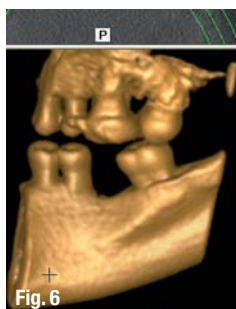


Fig. 6_CBT scan 15 months post-op LANAP.



Fig. 7_Pre-op photograph.

penetration. This ability to increase the depth of penetration of the laser energy with minimal collateral damage is the reason that the diseased epithelium can be selectively removed without damage to the underlying tissue, leaving intact rete pegs. The diode lasers are also known for this selective absorption in pigmented tissues, but the free-running, pulsed Nd:YAG lasers differ in their ability to operate at very high peak powers in very short timeframes, which allows the Nd:YAG to have the greater depth of penetration and the lack of collateral damage (Fig. 1).

Step C

This step in the LANAP protocol is straightforward; it is just a matter of using the piezo-scalers to remove the calculus present on the root surfaces. The removal of calculus is believed to be easier after the interaction of the laser energy with the calculus. The first interaction of the laser results in the initial formation of a mini-flap, thereby further assisting in the removal of calculus because of increased visibility and access to the calculus.

Step D

The next step again utilises the laser. This time the parameters are varied to enhance the ability to form a fibrin clot to close the mini-flap and to disinfect the site again. The formation of the stable fibrin clot is significant, as it is stable for approximately 14 days. The role of the fibrin clot is to keep the sulcus sealed against bacterial infiltration and to prevent the growth of epithelium down into the sulcus. Other laser wavelengths not only lack the ability to form this stable fibrin clot, but also require repeated

treatments to prevent epithelium growth down into the sulcus. The ability to select the laser-tissue interaction specifically is unique to the PeriLase MVP-7 (Millennium Dental Technologies). Through the use of specific fibre sizes, energy, repetition rates, pulse durations and standardisation of the energy at the fibre tip, this protocol can be followed in a predictable and reproducible manner. The high standard of training that each LANAP doctor receives also contributes to the predictability of this protocol and to its safety. Patients often present with different tissue types along with different degrees of disease. One of the purposes of the hands-on training is learning to recognise these differences and how to change the laser parameters accordingly so that the desired laser-tissue interactions are achieved. (Fig. 2)

Step E

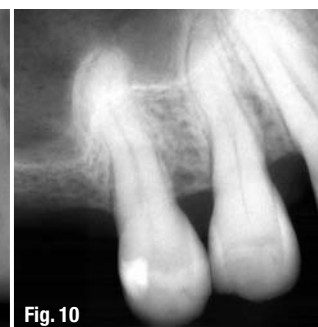
The fifth step in LANAP is the compression of the fibrin clot to enhance the healing process. Because laser wounds heal by secondary intention, closer approximation enhances the healing time.

Step F

Following the compression and stabilisation of the clot, the last step of LANAP is refining the occlusion. Occlusion has been considered a greater co-factor in the progression of periodontal disease than smoking. In order to minimise this role, extensive adjustments are made to the dentition.

The patients are then followed for nine to 12 months with routine supra-gingival cleanings and occlusal refinements. No sub-gingival restorative or periodontal probing is done during this time. Only during the final post-operative visit is a periodontal probing done.

The results that are seen from LANAP treatment are very similar to the following cases, where new bone fill can be seen in vertical osseous defects. The bone fill ranges from simple proximal defects to the more complex furcation defects. The hallmark of LANAP is pocket reduction, new tissue attachment and a lack of tissue recession.



_LANAP case 1

The patient in this case was a 40-year-old female patient with a history of lupus, rheumatoid arthritis and Sjögren's syndrome. She was also a smoker. There was generalised deep pocketing as seen in her periodontal charting (Fig. 3). The extent of the osseous defect is shown on the lingual view of the right quadrant preoperative CBT scan (Fig. 4). The initial post-LANAP evaluation was done at 15 months. Post-operative probing is shown in Figure 5. The CBT from the lingual view of the right quadrant at 15 months post-operatively is shown in Figure 6. The change in the osseous defects is apparent. Minimal to no recession is shown in the preoperative clinical photograph in Figure 7 and the post-operative in Figure 8.

_LANAP case 2

The patient in this case was a 59-year-old male patient, with Type 1 diabetes and a smoker. His periodontal pocketing was 7 mm on the mesial second premolar. The preoperative X-ray is shown in Figure 9 and the 36-month post-LANAP X-ray in Figure 10. The 7 mm pocket had been stable and maintained at 3 mm for the last 36 months. The LANAP protocol will be 21 years old this year. It is coming of age. It has stood

the test of time. There are over 1,000 trained clinicians applying LANAP. They have all been standardised. The uniqueness of the protocol is that whether the doctor is new to LANAP or a veteran "LANAP'er", his results are similar. During its early stages, early adopters accepted LANAP with anecdotal evidence alone, which was reinforced by the individual successes seen clinically. It was further validated by Dr Ray Yukna's histological studies in 2003. As the LANAP multicentre clinical studies move to completion, it would be reasonable to expect to see LANAP become the conventional manner or the standard for the treatment of periodontal disease. It is a very simple but eloquent protocol, one in which the patient has no to minimal discomfort and treatment acceptance is high.

_contact**laser****Dr David Kimmel**

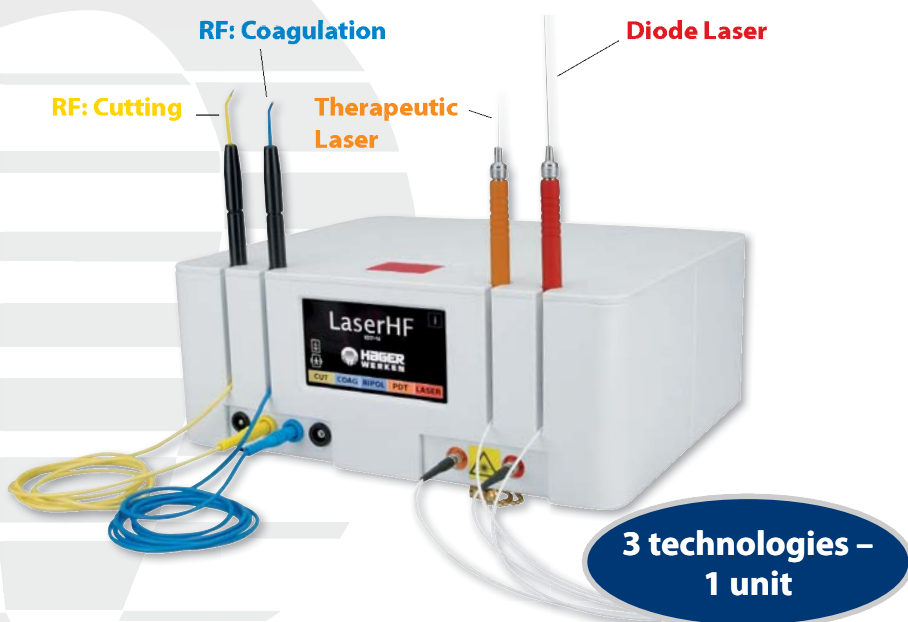
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